FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0010223

Facility Name: Odd Fellow-Rebekah Home

Address: 201 Lafayette Ave. (Number) Mattoon (City) 61938 (Zip Code)

County: Coles

Telephone Number: (217) 235-5449 **Fax #** ( )

IDPA ID Number: 370699717001

Date of Initial License for Current Owners: 05/01/77

Type of Ownership:

xx	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
xx	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: CRAIG L. ATER **Telephone Number:** ( )

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2002 to 06/30/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Kim Haas
(Title) Administrator

Paid Preparer

(Signed) (Date)
(Print Name and Title) Craig L. Ater
(Firm Name & Address) Heritage Enterprises
(Telephone) (309)823-7135 Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	162	Skilled (SNF)	162	59,130	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	162	TOTALS	162	59,130	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	31,042	18,481	4,191	53,714	8
9	SNF/PED			0		9
10	ICF					10
11	ICF/DD					11
12	SC	0	0	0		12
13	DD 16 OR LESS					13
14	TOTALS	31,042	18,481	4,191	53,714	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.84%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [xx]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [xx]

I. On what date did you start providing long term care at this location?
Date started 05/01/77

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [xx]

K. Was the facility certified for Medicare during the reporting year?
YES [xx] NO [ ] If YES, enter number of beds certified _____ and days of care provided 4,191

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [xx] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [xx] NO [ ]

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	237,945	30,231		268,176		268,176		268,176			1
2	Food Purchase		231,785		231,785		231,785		231,785			2
3	Housekeeping	150,513	21,255		171,768		171,768		171,768			3
4	Laundry	78,212	6,953		85,165		85,165		85,165			4
5	Heat and Other Utilities			164,661	164,661		164,661		164,661			5
6	Maintenance	160,395	47,343	23,778	231,516		231,516		231,516			6
7	Other (specify):*											7
8	**TOTAL General Services**	627,065	337,567	188,439	1,153,071		1,153,071		1,153,071			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	2,036,322	143,019	785	2,180,126		2,180,126		2,180,126			10
10a	Therapy		136,853	353,254	490,107	(137,635)	352,472		352,472			10a
11	Activities	106,880	5,135		112,015		112,015		112,015			11
12	Social Services	77,002		5,390	82,392		82,392		82,392			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,220,204	285,007	369,029	2,874,240	(137,635)	2,736,605		2,736,605			16
	C. General Administration											
17	Administrative	64,423			64,423		64,423		64,423			17
18	Directors Fees											18
19	Professional Services			351,218	351,218		351,218	(27,277)	323,941			19
20	Dues, Fees, Subscriptions & Promotions			131,034	131,034	(88,695)	42,339	(26,257)	16,082			20
21	Clerical & General Office Expenses	166,184	23,165	17,340	206,689		206,689		206,689			21
22	Employee Benefits & Payroll Taxes			645,624	645,624		645,624		645,624			22
23	Inservice Training & Education			1,999	1,999		1,999		1,999			23
24	Travel and Seminar			10,508	10,508		10,508	(8,509)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			143,541	143,541		143,541		143,541			26
27	Other (specify):*			73,779	73,779		73,779	(73,625)	154			27
28	**TOTAL General Administration**	230,607	23,165	1,375,043	1,628,815	(88,695)	1,540,120	(135,668)	1,404,452			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,077,876	645,739	1,932,511	5,656,126	(226,330)	5,429,796	(135,668)	5,294,128			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Odd Fellow-Rebekah Home #0010223 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			278,752	278,752		278,752		278,752			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			109,640	109,640		109,640	(4,315)	105,325			32
33	Real Estate Taxes			2,813	2,813		2,813		2,813			33
34	Rent-Facility & Grounds							(13,475)	(13,475)			34
35	Rent-Equipment & Vehicles			31,434	31,434		31,434	(6,328)	25,106			35
36	Other (specify):*											36
37	**TOTAL Ownership**			422,639	422,639		422,639	(24,118)	398,521			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					137,635	137,635		137,635			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					88,695	88,695		88,695			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**					226,330	226,330		226,330			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,077,876	645,739	2,355,150	6,078,765		6,078,765	(159,786)	5,918,979			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(6,328)	35		5
6	Rented Facility Space	(13,475)	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(4,315)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(180)	20		17
18	Fines and Penalties				18
19	Entertainment	(8,509)	24		19
20	Contributions	(25)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(27,277)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(73,600)	27		24
25	Fund Raising, Advertising and Promotional	(26,077)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (159,786)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (159,786)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Odd Fellow-Rebekah Home

ID# 0010223

Report Period Beginning: 07/01/2002

Ending: 06/30/2003

	NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		$			1
2					2
3					3
4					4
5			(6,328)	35	5
6			(13,475)	34	6
7					7
8					8
9			0	30	9
10				32	10
11					11
12					12
13			0	2	13
14				32	14
15			0	33	15
16				24	16
17			(180)	20	17
18					18
19				24	19
20			(25)	27	20
21					21
22			(27,277)	19	22
23					23
24			(73,600)	27	24
25			(26,077)	20	25
26					26
27					27
28					28
29					29
30					30
31					31
32					32
33					33
34					34
35					35
36					36
37					37
38					38
39					39
40					40
41					41
42					42
43					43
44					44
45					45
46					46
47					47
48					48
49	**Total**		(146,962)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Odd Fellow-Rebekah Home **#** 0010223 **Report Period Beginning:** 07/01/2002 **Ending:** 06/30/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(27,277)	0	0	0	0	0	0	0	0	0	0	(27,277)	19
20	Fees, Subscriptions & Promotions	(26,257)	0	0	0	0	0	0	0	0	0	0	(26,257)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(8,509)	0	0	0	0	0	0	0	0	0	0	(8,509)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(73,625)	0	0	0	0	0	0	0	0	0	0	(73,625)	27
28	**TOTAL General Administration**	(135,668)	0	0	0	0	0	0	0	0	0	0	(135,668)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(135,668)	0	0	0	0	0	0	0	0	0	0	(135,668)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 **Report Period Beginning:** 07/01/2002 **Ending:** 06/30/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,315)	0	0	0	0	0	0	0	0	0	0	(4,315)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(13,475)	0	0	0	0	0	0	0	0	0	0	(13,475)	34
35	Rent-Equipment & Vehicles	(6,328)	0	0	0	0	0	0	0	0	0	0	(6,328)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(24,118)	0	0	0	0	0	0	0	0	0	0	(24,118)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(159,786)	0	0	0	0	0	0	0	0	0	0	(159,786)	45

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 Report Period Beginning: 07/01/2002 Ending: 6/30/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Bonds--City of Mattoon		xx	Construction of 42 bed addition	$20,000.00	09/02/94	$ 2,800,000	$ 1,675,417	08/02/2014	0.0550	$ 109,640	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$20,000.00		$ 2,800,000	$ 1,675,417			$ 109,640	9
	B. Non-Facility Related*											
10	Interest Income										(4,315)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (4,315)	14
15	TOTALS (line 9+line14)						$ 2,800,000	$ 1,675,417			$ 105,325	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998		8
1999		9
2000		10
2001		11
2002		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Odd Fellow-Rebekah Home COUNTY Coles

FACILITY IDPH LICENSE NUMBER 0010223

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? ☐ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☐ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☐ NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Land			$ 437,500	1
2					2
3	TOTALS			$ 437,500	3

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120				$ 1,774,077	$		$	$	$	4
5					151,724						5
6	42				1,867,245						6
7											7
8											8
	Improvement Type**										
9	1979 Improvements			1979	28,527						9
10	1980 Improvements			1980	19,254						10
11	1981 Improvements			1981	45,037						11
12	1982 Improvements			1982	4,295						12
13	1983 Improvements			1983	106,089						13
14	1984 Improvements			1984	6,600						14
15	1985 Improvements			1985	34,689						15
16	1986 Improvements			1986	135,963						16
17	1987 Improvements			1987	1,732						17
18	1988 Improvements			1988	20,341						18
19	1989 Improvements			1989	322,810						19
20	1990 Improvements			1990	56,795						20
21	1991 Improvements			1991	25,089						21
22	1992 Improvements			1992	36,953						22
23	1993 Improvements			1993	16,174						23
24	1994 Improvements			1994	30,400						24
25	1995 Improvements			1995	48,815						25
26	1996 Improvements			1996	1,082,895						26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34	C/O Allocation										34
35	Book Depreciation					230,840		230,840		3,210,214	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Roof	1997	$ 349,692	$		$	$	$	37
38	Architect Fees	1997	3,203						38
39	Wallpaper	1997	2,692						39
40	Water Hydrant	1997	5,430						40
41	Sinks, Cabinets	1997	496						41
42	Baseboards	1997	350						42
43	Woodframe Shed	1997	7,704						43
44									44
45	Water Heater	1998	14,664						45
46	Painting & Wallcovering	1998	4,567						46
47	Double drive gate & locks	1998	982						47
48									48
49	Carpet cleaning	1999	919						49
50	Exterior doors	1999	1,481						50
51	Water Heater	1999	7,660						51
52	Room renovations (wall coverings, tile, electrical)	1999	5,494						52
53	Decorating	1999	1,052						53
54	Window parts	1999	541						54
55									55
56	Baseboards, wallpaper	2000	1,120						56
57	Power panels	2000	2,722						57
58	Electrical outlets	2000	561						58
59									59
60									60
61	Booster Installation	2001	2,032						61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,228,866	$ 230,840		$ 230,840	$	$ 3,210,214	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,228,866	$ 230,840		$ 230,840	$	$ 3,210,214	1
2									2
3	Heat Exchanger	2002	4,724						3
4	LAN	2002	3,142						4
5	Water Heater	2002	7,397						5
6	Interior Renovations -- Entry Way	2002	7,493						6
7									7
8	Boiler	2003	1,941						8
9	Compressor	2003	6,361						9
10	Temperature control	2003	1,941						10
11	A/C Unit	2003	1,000						11
12	Smoke Detectors	2003	1,882						12
13	Lobby renovations: Wall paper, paint, floor coverings	2003	41,598						13
14	Kitchen Hood	2003	1,840						14
15	Firewall / Roof safty improvments	2003	32,502						15
16	Water Heater	2003	7,300						16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,347,987	$ 230,840		$ 230,840	$	$ 3,210,214	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 975,538	$ 47,912	$ 47,912	$		$ 871,203	71
72	Current Year Purchases	45,807						72
73	Fully Depreciated Assets	189,631						73
74								74
75	TOTALS	$ 1,210,976	$ 47,912	$ 47,912	$		$ 871,203	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		85 Mercury	1985	$ 11,655	$	$	$		$	76
77		87 Ford Pickup	1987	8,676						77
78		94 van	1994	29,844						78
79										79
80	TOTALS			$ 50,175	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,046,638	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 278,752	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 278,752	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,081,417	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 25,106 Description: pager, computer equipment
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- COMMUNITY COLLEGE ☐
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$ 108,994	$		$ 108,994	1
2	Licensed Speech and Language Development Therapist		hrs			48,423			48,423	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			194,723	332		195,055	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				136,521		136,521	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					1,114			1,114	13
14	TOTAL			$		$ 353,254	$ 136,853		$ 490,107	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 **Report Period Beginning:** 07/01/2002 **Ending:** 06/30/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 805,220	$	1
2	Cash-Patient Deposits	17,254		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	703,726		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	74,599		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,600,799	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	6,923,849		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,122,790		16
17	Accumulated Depreciation (book methods)	(4,081,417)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	1,180,953		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,146,175	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,746,974	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 224,324	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	17,254		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	244,962		30
31	Accrued Taxes Payable (excluding real estate taxes)	31,028		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Escrow	(21,087)		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 496,481	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,675,417		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,675,417	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,171,898	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,575,076	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,746,974	$	48

***(See instructions.)**

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,402,139	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,402,139	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	172,937	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 172,937	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 4,575,076	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,303,601	1
2	Discounts and Allowances for all Levels	(1,233,500)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,070,101	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	930,836	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 930,836	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	2,962	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	13,475	16
17	Sale of Drugs	214,758	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	15,400	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 246,595	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,315	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,315	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,251,847	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,153,071	31
32	Health Care	2,874,240	32
33	General Administration	1,628,815	33
	B. Capital Expense		
34	Ownership	422,639	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37		145	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,078,910	40
41	**Income before Income Taxes (line 30 minus line 40)****	172,937	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 172,937	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,759	1,979	$ 43,318	$ 21.89	1
2	Assistant Director of Nursing	754	893	17,072	19.12	2
3	Registered Nurses	6,132	6,822	131,869	19.33	3
4	Licensed Practical Nurses	35,963	39,707	562,260	14.16	4
5	Nurse Aides & Orderlies	112,012	122,382	1,206,664	9.86	5
6	Nurse Aide Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,081	5,863	75,139	12.82	8
9	Activity Director					9
10	Activity Assistants	11,825	12,947	106,880	8.26	10
11	Social Service Workers	5,766	6,250	77,002	12.32	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	24,431	26,548	237,945	8.96	15
16	Dishwashers					16
17	Maintenance Workers	13,457	14,879	160,395	10.78	17
18	Housekeepers	15,792	17,469	150,513	8.62	18
19	Laundry	8,979	9,866	78,212	7.93	19
20	Administrator	2,080	2,080	64,423	30.97	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,595	12,786	166,184	13.00	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	255,626	280,471	$ 3,077,876 *	$ 10.97	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 0		35
36	Medical Director		9,600		36
37	Medical Records Consultant		0		37
38	Nurse Consultant				38
39	Pharmacist Consultant		0		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		5,390		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 14,990		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0		50
51	Licensed Practical Nurses		0		51
52	Nurse Aides		0		52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kim Hass	Admin	0	$ 64,423
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 64,423

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heritage Enterprises	Management Fees	$ 323,941
		0
		0
		0
Legal Fees (Adjusted to zero)		27,277
		0
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 351,218

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 76,774
Unemployment Compensation Insurance	16,524
FICA Taxes	235,458
Employee Health Insurance	300,108
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Hepatitis Vaccine	0
Employee Benefits -	16,760
Employee Benefits - central office	
TOTAL (agree to Schedule V, line 22, col.8)	$ 645,624

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 0
Advertising: Employee Recruitment	6,031
Health Care Worker Background Check	
(Indicate # of checks performed)	688
Central Office Allocation	
Promotional Advertising	20,650
Public Relations	5,427
Dues and Subscriptions	9,403
License and Fees	140
Less: Public Relations Expense	(5,427)
Non-allowable advertising	(180)
Yellow page advertising	(20,650)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,082

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	7,660
	128
Seminar Expense	2,720
Non Allowable	(8,509)
Central Office Allocation	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,999

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 Report Period Beginning: 07/01/2002 Ending: 06/30/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Odd Fellow-Rebekah Home # 0010223 **Report Period Beginning:** 07/01/2002 **Ending:** 06/30/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Healthcare Association**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,000** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **xx** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **No** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **88,695**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **5,663**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Pellman & Dold** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain. **Not Complete as of this date**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Account Number			Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3/4 Line #	Sch 5 pg 3/4 Col #	Sch 6 pg 5 Line #	Adjustment Amount								
1009			PETTY CASH	805,220							1,009	1010	CASH IN B	805,220			
1010			CASH IN BANK								1,100			703,726			
1040			CASH IN BANK-PAYROLL								1,101						
1100			ACCOUNTS RECEIVABLE	703,726							1,110						
1110			MEDICARE RECEIVABLES								1,125						
1125			IPA INCOME RECEIVABLE								1,135						
1130			MEDICARE COST REPORT								1,140						
1135			ACCOUNTS RECEIVABLE-IC								1,145						
1140			UNAPPLIED CASH RECEIPTS								1,200			74,599			
1145			A/R SUSPENSE-REFUNDS								1,220						
1190			ACCRUED INTEREST REC								1,300						
1200			PREPAID INSURANCE	74,599							1,310						
1220			OTHER PREPAID EXPENSES								1,320						
1300			FOOD INVENTORY								1,409						
1310			SUPPLIES INVENTORY								1,450			1,122,790			
1409			LAND	0							1,460			-871,203			
1450			FURNITURE & EQUIPMENT	1,122,790							1,475			6,923,849			
1460			ACCUM DEPR-FURN & EQUIP	-871,203							1,490			-3,210,214			
1475			BUILDING & IMPROVEMENTS	6,923,849							1,530			17,254			
1490			ACCUM DEPR-BUILDING	-3,210,214							1,550						
1530			RESIDENT FUNDS	17,254							1,551						
1550			LOAN FEES	0							1,850			1,180,953			
1560			REAL ESTATE TAX ESCROW								2,010			-224,324			
1575			REIMBURSABLE PURCHASES								2,100			0			
1850			INTRACOMPANY	1,180,953							2,100			-86,822			
2010			ACCOUNTS PAYABLE	-224,324							2,100						
2095			BONUSES PAYABLE								2,100						
2100			ACCRUED PAYROLL	-86,822							2,110			-158,140			
2110			ACCRUED VACATION PAY	-158,140							2,120						
2120			UC TAXES PAYABLE								2,125						
2125			FICA TAX PAYABLE	-31,028	-31,028						2,130			-31,028			
2130			FIT PAYABLE								2,140						
2140			STATE W/H PAYABLE		0						2,152						
2145			EARNED INCOME CREDIT								2,225						
2150			UC FED CREDIT REDUCTION								2,230						
2230			PAYROLL SAVINGS								2,235						
2235			IRA W/HOLDINGS								2,240						
2240			UNITED WAY								2,246						
2245			GROUP INSURANCE PAYABLE								2,250						
2246			GROUP INSURANCE PAYABLE-CAFETERIA								2,260						
2260			WAGE GARNISHMENTS								2,300						
2280			MISC PAYROLL DEDUCTIONS								2,320						
2300			ACCRUED INTEREST PAYABLE	0							2,350						
2310			SALES TAX PAYABLE								2,385			21,087			
2320			IPA PAYMENTS PAYABLE	0							2,400						
2350			REAL ESTATE TAX PAYABLE	0							2,512			-17,254			
2385			ACTIVITY FUND	21,087							2,600			-1,675,417			
2390			SECURITY DEPOSITS								2,600						
2391			VOLUNTEER FUND								2,625						
2393			HEART FUND/BAZAAR								2,625						
2395			DEFERRED INC EMP & MEM								2,695						
2400			CURRENT PORTION LT DEBT								2,720			-4,402,139			
2460			INCOME TAXES PAYABLE										net income	-172,937			
2512			DUE TO RESIDENTS	-17,254													
2600			MORTGAGE PAYABLE	-1,675,417													
2650			EQUIPMENT LOAN PAYABLE										balance	0			
2695			CURRENT PORTION LT DEBT														
2696			DEFERRED INCOME TAXES														
2710			COMMON STOCK														
2720			RETAINED EARNINGS	-4,402,139													
2970			PROFIT/LOSS FOR PERIOD	-172,937													
3007.1			PATIENT DAYS-PRIVATE	18,481											3,007		18,481
3007.2			PATIENT DAYS-IPA	31,042											3,007		31,042
3007.3			PATIENT DAYS-MEDICARE	4,191											3,007		4,191
3007.4			PATIENT DAYS-CONVERSION												3,007		
3007.5			PATIENT DAYS-LICENSED												3,007		
3007.6			PATIENT DAYS-TOTAL												3,007		
3010		1	BASIC CHARGE-PRIVATE & VA	-2,168,153		0	0	0	0						3,007		
3015		1	PRIVATE ASSESSMENT TAX INCOME			0	0	0	0						3,010	3,010 BASIC CH	(2,168,153)
3020		1	BASIC CHARGE-IPA	-2,541,012		0	0	0	0						3,020	3,020 BASIC CH	(2,541,012)
3030		1	BASIC CHARGE-MEDICARE	-1,239,249		0	0	0	0						3,030	3,030 BASIC CH	(1,239,249)
3035		4	DAY CARE/HOME CARE			0	0	0	0						3,040		
3040		1	LIGHT NURSING CARE	0		0	0	0	0						3,050		
3050		1	MEDIUM NURSING CARE			0	0	0	0						3,060		
3060		1	HEAVY NURSING CARE			0	0	0	0						3,061		
3061		1	SKILLED NURSING CARE												3,080	3,080 NURSING	(115,473)
3080		1	NURSING SUPPLIES-PRIVATE	-337,983		0	0	0	0						3,081	3,081 NURSING	(173,135)
3081		1	NURSING SUPPLIES-IPA			0	0	0	0						3,082	3,082 NURSING	(48,990)
3082		1	NURSING SUPPLIES MED PT A			0	0	0	0						3,083	3,083 NURSING	(385)
3083		1	NURSING SUPPLIES MED PT B												3,100	3,100 DRUGS-MI	(214,758)
3100		17	DRUGS	-214,758		0	0	0	0						3,101		
3101		17	DRUGS-OTHER												3,110		
3110		6	PT-PRIVATE	-930,836		0	0	0	0						3,111	3,111 PHYSICAL	(2,390)
3111		6	PT-IPA			0	0	0	0						3,112	3,112 PHYSICAL	(334,600)
3112		6	PT-MEDICARE PART A			0	0	0	0						3,113	3,113 PHYSICAL	(175,560)
3113		6	PT-MEDICARE PART B			0	0	0	0						3,140	3,140 LABORAT	(11,219)
3130		1	PUBLIC AID ASSESSMENT INC												3,150		
3140		19	LABORATORY INCOME			0	0	0	0						3,151	3,151 ST/OT THE	(80)
3150		6	SPEECH/OT-PRIVATE			0	0	0	0						3,152	3,152 ST/OT THE	(296,120)
3151		6	SPEECH/OT-IPA			0	0	0	0						3,153	3,153 ST/OT THE	(75,932)
3152		6	SPEECH/OT-MED PART A			0	0	0	0						3,160	3,162 AMBULAN	(34,935)
3153		6	SPEECH/OT MED PART B												3,410	3,410 IPA/OTHEI	206,866
3410		2	IPA DISCOUNTS	1,233,500		0	0	0	0						3,411	3,411 MEDICARI	82,793
3411		2	MEDICAID PART B DISCOUNT			0	0	0	0						3,420	3,420 MEDICARI	912,546
3420		2	MEDICARE DISCOUNTS			0	0	0	0						3,500		
3440		36	ASSESSMENT TAX EXPENSE			42	3	0	0						3,520	3,520 RENT INC(	(13,475)
3520		16	RENT INCOME	-13,475		6	0	6	-13,475						3,530		
3530		13	BEAUTY SHOP	0		0	0	0	0						3,560		
3560		12	ACTIVITY FUND INCOME	0		0	0	0	0						3,570	3,570 VENDING	(2,962)
3570		12	VENDING INCOME/EXPENSE	-2,962		0	0	0	0						3,590	3,590 EQUIPMEN	(17,204)
3580		12	MANAGEMENT FEES			0	0	0	0						3,595	3,595 RESIDENT	(5,290)
3590		1	EQUIPMENT RENTAL	-17,204		0	0	0	0						3,600	3,600 MISC INC(	(10,110)
3595		21	RESIDENT TRANSPORTATION	-5,290		0	0	0	0						4,110	4,110 G&A WAG	148,874
3600		21	MISC INCOME	-10,110		0	0	0	0						4,111	4,111 ADMINIST	64,423
4110			GENERAL & ADMINIST WAGES	148,874	166,184	21	1	17	0						4,115	4,115 G&A PTO	17,310
4111			ADMINISTRATOR WAGES	64,423	64,423	17	1	0	0						4,120	4,120 EMPLOYE	15,886
4115			VACATION & SICK - G&A	17,310		21	1	0	0						4,125		
4120	4475		EMPLOYEE BENEFITS	16,725	645,624	22	3	0	0						4,130		
4125			EMPLOYEE HEPETITIS VACCIN	0		22	3	0	0						4,135	4,135 EMPLOYE	35
4130			EMPLOYEE SCHOLORSHIP WA(	0		21	1	0	0						4,250	4,250 OFFICE SU	6,166
4135			EMPLOYEE SCHOLORSHIP COS	35		23	3	0	0						4,255	4,255 POSTAGE	3,662
4220			DIRECTORS FEES			18	3	0	0						4,260	4,260 TELEPHON	17,340
4250	4255		OFFICE SUPPLIES	23,165	23,165	21	2	0	0						4,275	4,275 TRAINING	1,999
4260			TELEPHONE	17,340	17,340	21	3	0	0						4,276		
4275			TRAINING & EMPLOYEE DEVL	1,999	1,999	23	3	16	0						4,280	4,280 GENERAL	7,660
4280			GENERAL TRAVEL	7,660	10,508	24	3	16	0						4,281	4,281 MEAL EXP	128
4281			MEAL EXPENSE FOR TRAVEL	128		24	3	19	0						4,285	4,285 EDUCATIO	2,720
4285			EDUCATION & SEMINAR	2,720		24	3	19	-8,509 ***						4,289		
4290			HELP WANTED ADVERTISING	6,031	131,034	20	3	0	0	-88,695					4,290	4,290 HELP WAN	6,031
4291			PROMOTIONAL ADVERTISING	20,650		20	3	25	-20,650						4,291	4,291 PROMOTI(	20,650
4292			PUBLIC RELATIONS	5,427		20	3	25	-5,427						4,292	4,292 PUBLIC RI	5,427
4300			LICENSES & FEES	88,835		20	3	17	0						4,300	4,300 LICENSE &	88,835
4310			DUES & SUBSCRIPTIONS	9,403		20	3	17	-180						4,310	4,310 DUES & SU	9,403
4320			CONTRIBUTIONS	25		27	3	20	-25						4,320	4,320 CONTRIBU	25
4350			PROFESSIONAL FEES	27,277	351,218	19	3	22	-27,277						4,350	4,350 PROFESSI(	27,277
4355			MEDICAL DIRECTOR	9,600	9,600	9	3	0	0						4,355	4,355 MEDICAL	9,600
4360			UTILIZATION REVIEW			10	3	0	0						4,362		
4361			OTHER PHYSICIAN FEES			39	3	0	0						4,363		
4362			MEDICAL RECORDS CONSULT	0		10	3	0	0						4,364	4,364 SOCIAL SE	5,390
4363			PHARMACIST FEES	0		10	3	0	0						4,370	4,370 TV RENTA	10,949
4364			SOC SERV/ACT CONSULT	5,390	5,390	12	3	0	0						4,383	4,383 BACKGRO	688
4370			TV RENTAL	10,949		35	3	5	-6,328						4,390	4,390 OTHER TA	2,288
4380			INCOME TAXES		73,779	27	3	26	0						4,400	4,400 PAYROLL	245,295
4383			BACKGROUND CHECKS	688		20	3	26	0						4,401	4,401 PAYROLL	6,687
4400			PAYROLL TAXES	245,295		22	3	0	0						4,410	4,410 GROUP IN	300,108
4401			PAYROLL TAXES ADMINIST	6,687		22	3	0	0						4,420	4,420 LIABILITY	143,541
4410			GROUP INSURANCE	300,108		22	3	0	0						4,430	4,430 WORKMAI	73,150
4420			LIABILITY INSURANCE	143,541	143,541	26	3	0	0						4,435	4,435 W/C-FIRST	2,691
4425			INSURANCE-OWNERS			22	3	21	0						4,436	4,436 DRUG TES	933
4430			WORKMENS COMP INSURANCI	76,774		22	3	0	0						4,450	4,450 MANAGEI	323,941
4450			CENTRAL OFFICE FEES	323,941		19	3	34	0 **						4,460	4,460 BAD DEBT	73,600
4460			BAD DEBTS	73,600		27	3	24	-73,600						4,461	4,461 BAD DEBT	31,295
4470			LOST ITEMS-RESIDENTS	154		27	3	0							4,470	4,470 LOST ITEM	154
4490			MISCELLANEOUS	0		27	3	0	0						4,475	4,475 UNIFORM	839
4510			REAL ESTATE TAXES	2,813	2,813	33	3	0	0						4,486	4,486 SERVICE (	2,940
4600			LEASED EQUIPMENT	20,485	31,434	35	3	16	0						4,490	4,490 MISC EXPI	386
5110			MAINTENANCE SALARIES	148,186	160,395	6	1	0	0						4,496	4,496 MISC. M.I.	13,337
5120			MAINTENANCE SICK & VAC	12,209		6	1	0	0						4,510	4,510 REAL EST.	2,813
5130			ELECTRIC	84,539	164,661	5	3	0	0						4,600	4,600 LEASED E	20,485
5131			NATURAL GAS	37,165		5	3	0	0						5,110	5,110 MAINTEN	148,186
5132			HEATING & DEISEL OIL			5	3	0	0						5,120	5,120 MAINTEN	12,209
5133			WATER & SEWER	42,957		5	3	0	0						5,130	5,130 ELECTRIC	84,539
5134			TRASH COLLECTION	9,856	23,778	6	3	0	0						5,131	5,131 NATURAL	37,165
5140			PROPERTY PLANT REPLACEMI	10,302	47,343	6	2	0	0						5,133	5,133 WATER &	42,957
5160			GENERAL REPAIR & MAINT	37,041		6	2	0	0						5,134	5,134 TRASH CO	9,856
5165			MAINTENANCE CONTRACTS	13,922		6	3	0	0						5,140	5,140 PROP/PLA	10,302
5210			DIETARY WAGES	220,148	237,945	1	1	0	0						5,160	5,160 GENERAL	37,041
5220			DIETARY SICK & VAC	17,797		1	1	0	0						5,165	5,165 MAINTEN	10,982
5240			SALES TAX			2	3	13	0						5,210	5,210 DIETARY	220,148
5248			FOOD PURCHASES	237,448	231,785	2	2	0	0						5,220	5,220 DIETARY I	17,797
5250			SUPPLIES-DISHWASHING	6,961	30,231	1	2	0	0						5,248	5,248 FOOD PUR	237,062
5260			DIETARY REPLACEMENT	5,284		1	2	0	0						5,250	5,250 SUPPLIES	6,961
5270			KITCHEN SUPPLIES-PAPER	17,986		1	2	0	0						5,260	5,260 REPLACEI	5,284
5295			MEAL CREDIT	-5,663		2	2	0	0						5,270	5,270 KITCHEN	17,986
5310			LAUNDRY WAGES	73,706	78,212	4	1	0	0						5,295	5,295 MEAL INC	(5,663)
5340			LAUNDRY SICK & VAC	4,506		4	1	0	0						5,310	5,310 LAUNDRY	73,706
5370			LAUNDRY REPLACEMENT	2,072	6,953	4	2	0	0						5,340	5,340 LAUNDRY	4,506
5380			LAUNDRY REIMBURSEMENT			4	3	0	0						5,370	5,370 REPLACEI	2,072
5390			LAUNDRY SUPPLIES	4,881		4	2	0	0						5,380		
5410			HOUSEKEEPING WAGES	139,770	150,513	3	1	0	0						5,390	5,390 SUPPLIES	4,881
5440			HOUSEKEEPING SICK & VAC	10,743		3	1	0	0						5,410	5,410 HOUSEKE	139,770
5480			HOUSEKEEPING SUPPLIES	5,473	21,255	3	2	0	0						5,440	5,440 HOUSEKE	10,743
5490			HOUSEKEEPING SUPPLIES-PPR	15,782		3	2	0	0						5,480	5,480 SUPPLIES-	5,473
6010			RN WAGES-MEDICARE		2,036,322	10	1	0	0						5,490	5,490 SUPPLIES-	15,782
6020			RN WAGES-NON MEDICARE	118,435		10	1	0	0						6,020	6,020 RN WAGE	118,435
6030			DON WAGES	43,318		10	1	0	0						6,030	6,030 DON WAG	43,318
6035			ADON	17,072		10	1	0	0						6,035	6,035 ADON WA	17,072
6040			RN SICK & VACATION	13,434		10	1	0	0						6,040	6,040 RN PTO &	13,434
6110			LPN WAGES-MEDICARE			10	1	0	0						6,120	6,120 LPN WAGI	540,094
6120			LPN WAGES-NON MEDICARE	540,094		10	1	0	0						6,140	6,140 LPN PTO &	22,166
6130			LPN WAGES OTHER			10	1	0	0						6,220	6,220 AIDES WA	1,141,198
6140			LPN SICK & VACATION	22,166		10	1	0	0						6,240	6,240 AIDES PTC	65,466
6210			AIDE WAGES-MEDICARE			10	1	0	0						6,245		
6220			AIDE WAGES-NON MEDICARE	1,141,198		10	1	0	0						6,246		
6230			WARD CLERKS			10	1	0	0						6,247		
6240			AIDE VACATION & SICK	65,466		10	1	0	0						6,250		
6245			CONTRACT NURSES-RN	0		10	3	0	0						6,255		
6246			CONTRACT NURSES-LPN	0		10	3	0	0						6,260		
6247			CONTRACT NURSES-AIDES	0		10	3	0	0						6,270	6,270 REHAB W.	74,131
6250			NURSE AIDE TRAINING WAGES	0	0	13	1	0	0						6,275	6,275 REHAB PT	1,008
6255			NURSE AID TRAINING EXP	0	0	13	2	0	0						6,290	6,290 NURSING	103,005
6260			NURSE AIDE TRAINING REIMB	0		0	0	0	0						6,295	6,295 NURSING	33,958
6270			REHAB WAGES	74,131		10	1	0	0						6,390	6,390 REPLACEI	6,056
6275			REHAB SICK & VAC	1,008		10	1	0	0						6,490	6,490 OTHER	785
6280			NURSING DEPT EDUCATION			23	3	0	0						7,280	7,280 DRUG PUI	130,271
6290			NURSING SUPPLIES	103,005	143,019	10	2	0	0						7,281	7,281 DRUG PUI	6,250
6295			NURSING SUPPLIES	33,958		10	2	0	0						7,380	7,380 LABORAT	1,114
6390			REPLACEMENT-NURSING	6,056		10	2	0	0						7,391		
6490			NURSING OTHER	785	785	10	3	0	0						7,393		
7280			DRUG PURCHASES	130,271	136,853	39	2	0	0 ***						7,510	7,510 ACTIVITIE	104,015
7281			DRUG PURCHASES-OTHER	6,250		39	2								7,540	7,540 ACTIVITIE	2,865
7380			LABORATORY SERVICES	1,114	353,254	39	3	0	0						7,590	7,590 ACTIVITIE	5,135
7410			HOME HEALTH SALARY			39	1	0	0						7,620	7,620 PHYSICAL	194,723
7440			HOME HEALTH SICK & VAC			39	1	0	0						7,660	7,660 P.T. SUPPL	332
7450			HOME HEALTH EXPENSES			39	3	0	0						7,710	7,710 SOCIAL SE	73,474
7510			ACTIVITES WAGES	104,015	106,880	11	1	0	0						7,720	7,720 SOCIAL SE	3,528
7540			ACTIVITIES SICK & VAC	2,865		11	1	0	0						7,730		
7590			ACTIVITIES SUPPLIES	5,135	5,135	11	2	0	0						7,740	7,740 OCCUPAT	108,994
7595			ACTIVITIES FEES	0	0	11	3	0	0						7,750		
7610			PT WAGES			39	1	0	0						7,770	7,770 SPEECH TI	48,423
7611			PT SICK & VACATION			39	1	0	0						7,820		
7620			PT FEES	194,723		39	3	0	0 ***						7,890		
7660			PT SUPPLIES	332		39	2	0	0						7,960		
7710			SOCIAL SERVICE WAGES	73,474	77,002	12	1	0	0						8,120	8,120 INTEREST	109,640
7720			SOCIAL SERVICE SICK & VAC	3,528		12	1	0	0						8,125		
7730			SOCIAL SERVICE EXPENSES	0	0	12	2	0	0						8,130	8,130 DEPRECIA	278,752
7740			OT FEE	108,994		39	3	0	0 ***						8,150		
7750			SOCIAL THERAPIST FEE	0	0	12	3	0	0						9,510	9,510 INTEREST	(4,315)
7770			SPEECH THERAPY FEE	48,423		39	3	0	0 ***						9,520	9,520 MISC NON	(2,143)
7800			BEAUTICIAN WAGES		0	40	1	0	0						9,530		
7810			BEAUTICIAN SICK & VAC			40	1	0	0								
7820			BEAUTICIAN FEES	0	0	40	3	0	0								-172,937
7890			BEAUTY SHOP SUPPLIES	0	0	40	2	0	0								
7910			VOLUNTEER COORDINATOR			21	1	0	0								
7940			VOL COORD SICK & VAC			21	1	0	0								
7960			VOL COORD SUPPLIES	0		21	2	0	0								
8100			RENT		0	34	3	0	0								
8120			INTEREST EXPENSE	109,640	109,640	32	3	14	-4,315								
8130			DEPRECIATION	278,752	278,752	30	3	9	0								
8150			LOAN FEE AMORTIZATION	0		32	3	0	0	60,773							
9510			INTEREST INCOME	-4,315		32	0	10	0								
9520			MISC NON-OPERATING INCOM	0		0	0	0	0								
9700			INCOME TAXES	145		0	0	0	0								
				6,074,595	6,078,765												
					4,170												
GRAND TOTALS				-172,937					-159,786								
				(NET INCOME)													
				0													
			FACILITY NAME:														
			FACILITY ID:	0													
			FACILITY UNITS:	89													
			BALANCE SHEET TOTAL	0													
				173,113													

	G/L	RECAP CENSUS
PP	18,481	18,481
IPA	31,042	31,042
medicare	4,191	4,191
		53,714
IPA BEDHOLDS	0	
PP BEDHOLDS	0	
PP CONVERS	0	